



2016 KEHP UPDATE FORM

To be completed by Insurance Coordinator/HR Generalist only. **DO NOT** use this form to add or drop dependents.
This form is to be used to update information on health insurance, FSA and HRAs.

General Information (required)			
Name:		Personnel Number:	SSN:
Organizational Unit:		Company Number:	Company Name:

Update Reason									
<input type="checkbox"/> Termination: Date Employment Ends _____ Date Health Insurance Terminates _____ Reason: <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> LWOP <input type="checkbox"/> Death <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____									
<input type="checkbox"/> Reinstate Coverage: Date Returned to Work _____ Date Insurance Effective _____ Reason: <input type="checkbox"/> Rehired <input type="checkbox"/> FMLA <input type="checkbox"/> LWOP <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____									
<input type="checkbox"/> Transfer or Summer Transfer <ul style="list-style-type: none"> ▪ To be completed by the NEW company ▪ No changes to current coverage allowed <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td>Prior Company Number _____</td> <td>New Company Number _____</td> </tr> <tr> <td>Last Day Worked at Prior Company _____</td> <td>Date Hired at New Company _____</td> </tr> <tr> <td>Coverage End Date at Prior Company _____</td> <td>Coverage Begin Date at New Company _____</td> </tr> </table>				Prior Company Number _____	New Company Number _____	Last Day Worked at Prior Company _____	Date Hired at New Company _____	Coverage End Date at Prior Company _____	Coverage Begin Date at New Company _____
Prior Company Number _____	New Company Number _____								
Last Day Worked at Prior Company _____	Date Hired at New Company _____								
Coverage End Date at Prior Company _____	Coverage Begin Date at New Company _____								
Is Member Cross Reference <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Benefit Option <input type="checkbox"/> LivingWell CDHP <input type="checkbox"/> LivingWell PPO <input type="checkbox"/> Standard PPO <input type="checkbox"/> Standard CDHP	Current Coverage Level <input type="checkbox"/> Single (self only) <input type="checkbox"/> Parent Plus (self and child(ren)) <input type="checkbox"/> Couple (self and spouse) <input type="checkbox"/> Family (self, spouse and child(ren))							

Other Changes or Corrections			
For: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			
Name	New:		
	Previous:		
New Address (where mail received)		Street Address:	
		City:	State: Zip Code:
E-Mail Address			
SSN	Correct:		Incorrect:
	Date of Birth		Incorrect:
Other			

I acknowledge and understand that DEI will comply with HIPAA rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.

Employee Signature	Date
Insurance Coordinator/HRG Signature	Date
IC/HRG Printed Name	IC/HRG Phone Number